Medicaid Treatment Plan

Agency Name

Agency Address

Identifying Information

Name: Age:

Ethnicity: Gender:

Medicaid Number:

Individual(s) present:

Service Rendered:

Setting of Service:

Start Time: End Time: Duration:

Service Provider:

Date of Report:

Statement of disability and need for mental health therapy:

Based on mental health assessment results

Treatment Goal One:

Identify specific treatment goal based upon assessment results

Specify SMART objectives related to achieving the treatment goal

Treatment Method:

Individual, family, or group therapy

Therapeutic Modality:

DBT, CBT, EMDR

Frequency and Duration of treatment:

Weekly sessions of 60 minutes duration

Treatment Review or resolved Date:

Date treatment goal is reviewed or resolved

Treatment Goal Two:

Identify specific treatment goal based upon assessment results

Specify SMART objectives related to achieving the treatment goal

Treatment Method:

Individual, family, or group therapy

Therapeutic Modality:

DBT, CBT, EMDR

Frequency and Duration of treatment:

Weekly sessions of 60 minutes duration

Treatment Review or resolved Date:

Date treatment goal is reviewed or resolved

Treatment Goal Three:

Identify specific treatment goal based upon assessment results
Specify SMART objectives related to achieving the treatment goal
Treatment Method:
Individual, family, or group therapy
Therapeutic Modality:
DBT, CBT, EMDR
Frequency and Duration of treatment:
Weekly sessions of 60 minutes duration
Treatment Review or resolved Date:
Date treatment goal is reviewed or resolved

Treatment Goal Four:
Identify specific treatment goal based upon assessment results
Specify SMART objectives related to achieving the treatment goal
Treatment Method:
Individual, family, or group therapy
Therapeutic Modality:
DBT, CBT, EMDR
Frequency and Duration of treatment:
Weekly sessions of 60 minutes duration
Treatment Review or resolved Date:
Date treatment goal is reviewed or resolved

Discharge Plan:
Describe discharge criteria related to the treatment goals/objectives
Describe tentative discharge plans
Identify community resources needed to implement the plans

I have reviewed the treatment plan with the client: Y /N

Client Signature: Date:

Parent Signature: Date:

Licensed Therapist Signature: Date:
Include credential and title

Clinical Supervisor Signature: Date:
Include credential and title
(If necessary)